FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1401	A. BUILDING 02 - STATE BUILDING B. WING	09/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY MANOR INC	120 PITCOCK LANE CELINA, TN 38551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	1200-8-6-.08(2) Building Standards (2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on observations during the survey, it was determined the facility failed to maintain the condition of the physical plant as required. The findings include: 1. On 9/13/10 at 11:40 a.m., observation within resident room 103 revealed the night light was out. Tennessee Department Of Health (TDOH) 1200-8-6-.08(2) 2. On 9/13/10 at 2:05 p.m., observation within resident room 306 revealed the night light was out. Tennessee Department Of Health (TDOH) 1200-8-6-.08(2) These findings were acknowledged by the Maintenance Supervisor and verified by the Administrator during the exit interview on 9/13/10.	N 832	N832 1. The night lights in rooms 103 and 306 were replaced on 9/14/10 by the Director of Maintenance. 2. A review of the night lights in the building by the Director of Maintenance was conducted on 9/14/10 to identify any other areas of deficiencies. 3. The maintenance department was inserviced on 9/14/10 regarding proper maintenance of the electrical systems by the Administrator. 4. The maintenance director will examine the electrical systems weekly for four weeks and then monthly thereafter to ensure that they are in proper working order. All results will be reported to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	Completion Date 9/25/10

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Boone

TITLE: Administrator

(X6) DATE: 9/29/10

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